Zahnarztpraxis für Orale Implantologie und Rekonstruktive Zahnmedizin AG
PD Dr. med. Monika Laass / Dr. med. dent. Andrea Laass
Universitätstr. 102 , CH- 8006 Zürich
Tel. 044 363 14 40 www.zhdent.ch

□ Mr □ Mrs □ Child

Name / Title: _____ First Name: _____

Street: _____ Zip/Town: _____

Tel.Home: _____ Tel.Office: _____

Mobile: _____ Date of Birth: _____

E-Mail: _____

Occupation: _____

AHV-Nr: _____
(Not obligatory)

Family doctor: _____

Legal representatives (for children):

_____

_____

Please tick

Have you been emitted to hospital or

had medical treatments in recent years? □ Yes □ No

_____

Are you taking any medications? □ Yes □ No
If yes, which?

_____

_____

Are you taking medications against Osteoporosis □ Yes □ No
If yes, □ via tablet form or □ via injections
Name of medication _____ since when _____

Do you know about any allergies? □ Yes □ No
If yes, which?

_____

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Have you ever had or do you have:

- Difficulties with at lot of or longer bleeding? □ Yes □ No
- Heart or circulations problems? □ Yes □ No
- Diabetes? □ Yes □ No
- Diseases of the respiratory tract? □ Yes □ No
- Diseases of the liver or the kidney? □ Yes □ No
- Infectious diseases of any kind? □ Yes □ No
- Are you currently pregnant? □ Yes □ No
- Are you suffering of an unusual urge to gag? □ Yes □ No
- Would you like to receive your treatment under laughing gas/nitrous oxid? □ Yes □ No
- Do you smoke? □ Yes □ No

How would you like to manage the following correspondence options?

- Delivery of the bill □ via Post □ via Mail
- Delivery of cost estimation □ via Post □ via Mail
- Delivery of DH-Recalls, appointment reminder □ via Post □ via Mail
- Residual correspondence □ via Post □ via Mail

Hereby I give the permission, that the necessary patient information required for invoicing are allowed to be given to the invoicing body, to the debt collection authority and to the appropriate state authorities where necessary.
Debt collection agencies, magistrates and competent courts will receive no detailed information about the concrete medical treatment.
My doctor is allowed to order my medical files and to transfer them where necessary in my point of interest.

Date: _____ Signature: _____

Signature of the legal representatives (for children): _____